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An Address.[1]

By Sir David Hardie, Kt., M.D., LL.D.,
Retiring President of the Queensland Branch of the British Medical Association.

I have said that, except in one particular, the year which has just passed has been an uneventful one for this Branch of the Association. The exception I refer to is that of the Australasian Medical Congress, the eleventh session of which was held in Brisbane in the month of August. Our southern friends were good enough to tell us that the Congress was to them not only a profitable function, but a pleasurable one as well, and I am sure it was equally so, if not more so, to us.

The main feature of the Congress, as distinct from previous Congresses, was the discussion on the question of the settlement of the white race in tropical Australia and was worthy of the occasion. That discussion took place before full Congress and was followed by the passing of some important resolutions. As originally drafted, the resolutions covered a wide field for action and were non-committal. To these a further paragraph was finally tacked on, boldly declaring that "there were no inherent and insuperable obstacles in the way of the permanent occupation of tropical Australia by an indigenous white race," that the question is "fundamentally one of applied public health," that it "presents no difficulties beyond those of organization," or "the earnest and skilful application of the principles of statecraft" and, as a necessary saving clause, emphasizing the point "that any considerable extension of population and settlement under the existing loose conditions of sanitary administration and practice which prevail at the present time, cannot fail to result in ultimate disaster." In other words, the question is one that depends for its success on the administration of public health, organization and statecraft and, granted these, success is assured. (If I were inclined to be hypercritical, I should say that the last part of the above quotation is decidedly weak, because it emphasizes the need for improved sanitary administration only in the event of an extension of population. To my mind, colonization, in the absence of improved sanitary administration, will fail, even without an extensive increase in population.)

I cannot but applaud the hopeful spirit that finds expression in these resolutions and the methods by which the settlement of the white race in tropical Australia is to be brought to a successful issue.

Personally, I am not so sanguine and would have been more guarded in the expression of that opinion, but if an error has been made in that respect, it is an error in the right direction. Far better it is to be embued with the spirit of faith and hope than with the feeling that our efforts are doomed to fail.

This sanguine attitude has but one drawback and that is that if we are so cocksure of success the public is apt to make light of obstacles that will certainly be encountered and so make the measure of success all the less secure. For while we as medical men realize the importance of the saving clause above referred to, the public may lose sight of it. They are under the impression that the Congress has decided in favour of white colonization, forgetful of the proviso that we insist upon for success. It is absolutely necessary for us to drive home into their minds the expressed opinion of Congress that, unless certain conditions are complied with, the settlement of a white race in tropical Australia cannot fail to result in "ultimate disaster."

Failure to impress the public mind in this direction will result on their part in a sanguine attitude that reminds one of the attitude adopted by England and her allies in the early stage of the great war, when we all expected a fairly easy, if not a speedy, victory. That being denied us, we began to realize the enormity of the task in hand and not until we ultimately and fully appreciated its immensity, did we finally rise to the occasion until victory was assured. So the public must be made to realize that there are obstacles ahead in the occupation of tropical Australia by the white race and it seems to me the more we pay heed to these, the more likely shall our experiment be crowned with success. Let us be hopeful by all means—the more so the better—so long as our hopefulness is tempered with forethought against those forces that will exist and obstruct us by the way.

Let us see what justification there is for the faith that is in us. At the Congress meetings the question was discussed from the historical, statistical, physiological and economic points of view and I shall briefly take up these points *seriatim*.

I.—Historical.

So far it is generally recognized that this is not favourable, for up to the present time the Anglo-Saxon race has not succeeded in permanently settling in the tropics. That, however, is not conclusive evidence against the success of such settlement in Queensland.

In the first place, although a large part of this State is within the tropics, only a comparatively small portion of that area—the coastal area—can be said to have a tropical climate. On the highlands the climate is ideally perfect all the year round, while the western plateaux, if hot in summer, are dry and well suited for the maintenance of a strong, virile race. The coastal climate is the only one in doubt. That embraces but a small area and is within easy reach of the highland ranges, were we wise enough to take advantage of their proximity during the summer months. Personally, I look on these mountain resorts as a most valuable asset in the permanent occupation of our coastal areas by the white race. This point received confirmation from Professor Osborne, when he expressed doubt as to the suitability of north-western Australia for white colonization, because (amongst other reasons) there is "no escape to high altitudes."

In the second place, tropical hygiene, which is really our sheet anchor of hope for settlement in the tropics,

[1] Delivered at the Annual Meeting of the Queensland Branch of the British Medical Association on December 10, 1920.

is still in its infancy. It has already done much in other tropical countries. It is capable of doing much more in the future, so much that we are justified in believing that what has been impossible in the past, may be so no longer. In Queensland, hygiene has played but a small part in settlement—almost a negligible quantity. There is here a wide field open for its application that should yield a rich reward.

Again, tropical disease, as usually met with elsewhere, is, with the exception of hookworm disease, practically non-existent or, at any rate, as Dr. Breinl says, is "scarce and easily controlled."

Altogether, it may safely be stated that the failure of the Anglo-Saxon race to occupy elsewhere a tropical area permanently in the past is no proof that it will fail in Queensland.

II.—Statistical.

This aspect of the question was dealt with by Dr. Cumpston and Dr. Breinl, who showed that the death-rate and birth-rate of tropical Queensland compared favourably with those of the southern States and that, according to the Chief Actuary of the Australian Mutual Provident Society, "proponents for insurance in north Queensland were not treated differently from proponents who live in other parts of Australia."

This is highly satisfactory, but I am sure that neither of these authorities would advance the claim that the health statistics of the first or second generation of life in the tropics can possibly give any indication as to what these may be in the tenth or one hundredth generation or that because they are favourable for the present, they will be equally favourable a thousand years hence or for all time to come. If any such claim were made by any one, I can only say that I would admire the claimant more for his audacity than his judgement and if no such claim be made, statistics of the kind are worthless.

It is well to know that, for the present, the birth and death rates are favourable. That is a point worth emphasizing, to cheer us on our way, but they offer no justification for drawing inferences that can have no substantial significance for the generations to come.

Small indeed would be of our chance of success if such statistics were even but slightly unfavourable for the present generation. Whatever deterrent effect, if any, the climate may have on white colonization will only slowly show itself through many generations, as time goes by, and, so far, we have not got beyond the first or second generation.

Furthermore, is it not worth bearing in mind that gastro-enteric troubles, if they do not swell the death-rate, are common in the tropics and have a more lasting and deleterious influence on the vigour and stamina of the race than the pneumonias and acute respiratory disease of colder climates?

I confess the statistical argument does not appeal to me, because it does not and cannot allow for what, in my opinion, is absolutely essential—time for constitutional changes that, under tropical conditions of life, may or may not show themselves in future generations; time to show whether, if any such changes do occur, they may lead to a degenerate race, or whether the "adaptability" of the Briton, as Professor Osborne expresses it, may fit him to perpetuate without deterioration for all time to come the grand old stock from which he sprung.

III.—Physiological.

Professor Osborne and Dr. Breinl remind us that the temperature of the body rises under exertion in the tropics more readily than in colder climates, but assure us that this rise is slight and should have no deterrent effects. They also tell us that pallor of the skin does not indicate anæmia and is but skin deep.

What explanation is to be given for the lassitude and tired feeling so graphically described by Dr. Nisbet? Is it due to error in diet or clothing, or want of outdoor exercise in one who, after all, is unable or has not the chance to take the necessary exercise, or is it due to imperfect metabolism of purely climatic origin? Whatever the cause and significance of its existence, it is one of the most pronounced features of tropical life for white people, especially for women, and at least shows that all is not well.

One would like to know what the cumulative effect of physiological changes, slight though they are for the present, may be through successive generations. That belongs to the future.

IV.—Economic.

This seems to me a question with immense potentiality, but because of the scantiness of population and the absence of industrial undertakings remains an unknown quantity. When competing in the world's markets, the success of an industry depends upon the cost and efficiency of labour. If the former be higher and the latter lower than those prevailing outside Australia, the industry, as a world industry, will fail and settlement will fail with it.

So far as efficiency is concerned, we have Dr. Breinl's authority that "their working efficiency during winter showed no difference from that during the summer." On the other hand, he tells us that the shipping companies in Townsville estimate a decrease of 11% in efficiency amongst wharf-labourers during the hottest months of the year. Further evidence is required in this direction.

What may be the cost of labour no one knows. We know that in the sugar industry it has been high—so high that, but for a protective tariff, the industry would have collapsed years ago. Protection may enable the industry to supply the Australian population, but is powerless to help it to compete in the world's market. Should a similar protective tariff or a subsidy be required to bolster up other industries, are our southern friends prepared to pay the price? "If," in the words of the resolution, "the Australian nation wills the end, it must also will the means."

Looked at, therefore, from all points of view, while the outlook is hopeful, there is uncertainty as to the ultimate result of our attempt to settle a white race permanently in tropical Queensland. It is this uncertainty that should make us guarded in giving expression to our opinion and, with Professor Osborne, to declare honestly that we "do not know." Nor, to my mind, can this be known during our lifetime, nor for many years thereafter.

We all agree that the case against tropical Queensland has not been proved. That verdict I thoroughly endorse. Nor, may I add, has the case in favour been proved.

One thing, at least, we can say and that is that if we go on, as we are now doing, in a haphazard, happy-go-lucky style, our enterprise will result in "ultimate disaster." Call this pessimism if you life. It is preferable to ostrich-like myopia that blindfoldedly leads to failure in the long run and it is well that the resolution of Congress clearly pointed out what the result would be.

The optimism we need is the optimism of a Lloyd George, who, in the indomitable spirit of determination to win through, saw with prudent forethought and had the sense to make others see the almost insuperable obstacles that barred the way, the removal of which was necessary before we cleared the way to victory.

So let us not sit complacently in the hope that all may be well in the end, without an attempt, greater than is now being made, to further the cause of permanent occupation and race continuance in tropical Queensland.

It is for us as medical men to lead the way in so far as we can help towards this realization. We cannot do better than follow in the lines indicated in the resolutions originally drafted by the committee, which, with the addition of a further paragraph, were passed by Congress.

Resolutions as such, however, are useless, unless followed up by action, failing which, they are a dead letter and might as well never have seen the light of day.

Professor Osborne reminds us that one specialist cannot solve this "very complex problem." Nor, may I venture to add, can it be solved in the laboratory or office of many specialists, unless in collaboration with the labourer, be he public health officer, medical practitioner, statesman or settler, in the wider and more practical field of nature. Nor in any case can it be solved in our day. It is a question for the future and perhaps the distant future.

Meantime, let us realize that in tropical Queensland we have a goodly heritage worth fighting for and that it must be kept for the white race and the white race alone. If there are obstacles by the way—and we know there are—let us do our best to overcome them and carry on in the hope and belief that our efforts will be crowned with success.

ACUTE PERFORATION OF GASTRIC AND DUODENAL ULCER, WITH NOTES OF TWENTY-FIVE CASES.[1]

By John L. McKelvey, M.B., Ch.M.,

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Acute perforation is the gravest complication of gastric or duodenal ulcer. Other complications, such as hæmorrhage, though alarming, may not prove fatal, even if untreated, but acute perforation, unless treated surgically, almost in every case goes with varying speed to a fatal ending. The deciding cause in the acute perforation is not always the same, nor is it always evident. In some an indiscretion in diet, such as a meal containing carrots, may precede the perforation and the carrots with other débris may be found in the abdominal cavity. Pressure on the abdominal wall may be the determining factor, as in the case of a clerk who lifted a large ledger by pressing one edge against his epigastrium, or muscular effort, as shown by a carpenter reaching out to drive a nail. In many cases, however, no factor is apparent; there may have been no increase of symptoms prior to the catastrophe or the patient may have had no symptoms at all, the ulcer being "latent" or regarded as cured. Some patients, however, complain that their pain has been worse for some time prior to the perforation, as if some more active infection and ulceration were progressing. The severity of the symptoms of an ulcer bears no ratio to the tendency to perforate, for some patients may have marked symptoms for years without perforation, while in others perforation takes place with but mild or no symptoms at all. In perforation of that rarer form of ulcer—gastro-jejunal or jejunal—following gastro-enterostomy an unabsorbable stitch, such as thread or silk, plays a large part, as in a case seen with another surgeon. This patient had had a posterior gastro-enterostomy done eighteen months previously; his symptoms recurred and later he had an attack typical of a perforated ulcer. A ruptured gastro-jejunal ulcer was diagnosed provisionally and found at operation with the silk suture floating from the perforation and attached at one end to the floor of the ulcer. It is doubtful if unabsorbable sutures are necessary in stomach surgery. Acute perforations do not always occur into the peritoneal cavity. The ulcer may have adhered to some hollow viscus and perforated into it, producing an "internal duodenal fistula." Such fistulæ have been recorded as occurring into the stomach, gall bladder, colon and even into the pancreatic duct.

The Symptoms and Signs of Acute Perforation.

To the patient pain and to the surgeon rigidity are the outstanding features of the crisis. The pain is sudden; it is severe, almost beyond description or endurance and the patient holds his viscera in a muscular vice to prevent movement and thus to allay his suffering; his breath coming in gasps owing to the fixation of his diaphragm. At the moment of perforation he may fall down. He looks pale and shocked and the shock may be so great as to cause sudden death, as recorded by Moynihan. When seen by the surgeon he is lying on his back with his knees drawn up, his face troubled with pain, but not anxious, as it becomes later in advanced peritonitis. He resents the examining hand owing to the abdominal tenderness, but his pulse may be excellent in rate and volume and it is hard to believe that so grave a condition can be present with so good a pulse. Later the pulse-rate rises with increasing peritonitis, and when it is 115-120, the patient's chance of life is ebbing fast. The site of the pain is important. As the majority of duodenal ulcers are on the first part, the pain of perforation of these ulcers is felt generally to the right of the middle line.

[1] Read at a Meeting of the New South Wales Branch of the British Medical Association on November 12, 1920.

As the duodenal contents can trickle round the right colic (hepatic) flexure, down the ascending colon to the caecum, the latter may be bathed almost at the first gush with infective material and the consequent pain and tenderness in the caecal region may suggest acute appendicitis, a diagnosis made in five of these cases. A similar condition may arise in the rupture of a hydatid cyst of the right lobe of the liver when the fluid and daughter cysts gravitate to the caecum. In such a case a diagnosis of ruptured appendix was made, but at operation a cyst of the right lobe of the liver was found and daughter cysts falling like marbles from a perforation of its lower surface. In the rupture of a gastric ulcer the pain is generally in the mid-line or to the left of it. The patient may vomit or have nausea in the early stage, but vomiting is a sign rather of peritonitis than of the perforation. The physical signs may be divided into two groups:—

(*i.*) Those of the perforation.
(*ii.*) Those of the subsequent peritonitis or abscess.

(i.) Signs of Perforation.

Rigidity is the outstanding sign of perforation. It reaches a degree not approached by any other abdominal condition. On palpation the upper abdominal muscles feel like a metal plate and this rigidity may involve the diaphragm, as suggested by the short and gasping respiration. The patient lies quite still, afraid to move, almost afraid to breathe. This tonic contraction of muscles not only produces some retraction of the abdominal wall which gradually disappears with the advance of peritonitis, but also limits its movement during the respiratory excursions. Free fluid may be detected in the flanks. The pulse-rate increases as peritonitis developes, becomes small, hard and wiry; vomiting begins; the tongue, at first moist, becomes dry, red and fissured; the abdomen distends; the tenderness spreads; constipation is obstinate and the anxious Hippocratic face, with capillary stasis and cold, clammy extremities, show that the end is near. The temperature varies but little; at first sub-normal from shock, later rising slightly as peritonitis developes. A high temperature suggests some other condition than perforation. Absent liver dulness is a sign of doubtful assistance and the abdominal reflexes are lost in rigidity.

In some cases the clinical picture is not so definite, the rigidity is not characteristic and the signs so limited to the caecal region that appendicitis is diagnosed. In those rare cases which become shut off, one of the varieties of subphrenic abscess may form, the signs of which are outside the scope of this paper.

The diagnosis involves two questions:—

(1) That the lesion is a perforation.
(2) Whether it is gastric or duodenal.

The clinical picture of perforation with its characteristic rigidity in most cases is outlined so faithfully that the diagnosis is clear, but in some a doubt exists and then the commonest condition to differentiate is acute appendicitis. The reason for this has been indicated already. It may be said that the rigidity of appendicitis is rarely as great as in perforation; the point of maximum tenderness is lower down and a history of previous characteristic indigestion assists in pointing to an ulcer. In the early stages a leucocytosis does not help much, as it is the response to infection and takes time to develope.

An acute perforation of the gall bladder may simulate a duodenal perforation, but this occurs after an attack of acute cholecystitis has been in progress sufficiently long to allow a diagnosis of gall bladder disease to be made. A rupture of a hydatid cyst of the liver may be accompanied by great pain, shock and rigidity and the appearance of an urticarial rash and the presence of increased liver dulness may suggest the true condition. It is said that in gastric and duodenal perforation an exquisitely tender spot is to be made out over the point of perforation. This has not been evident in this series of cases. Acute pancreatitis is not followed by such marked rigidity; the face is often cyanotic, a history of gall stone attack may be given and the condition generally resembles intestinal obstruction rather than perforation; the tender, swollen pancreas may even be felt. A disease to be remembered and carefully differentiated not only from perforated ulcers, but from all acute abdominal conditions, is a basal pneumonia with either costal or diaphragmatic pleurisy. It often produces some hardness of the abdominal wall and this with the catchy respiration may simulate an acute abdominal lesion. If this disease is suspected, the patient is saved from an unnecessary operation, for careful examination will reveal usually signs of pneumonia or pleurisy, altered pulse-respiration ratio and a rigidity which is intermittent. Lead colic is to be considered. One of the patients (B.O.) had been treated previously for this complaint. The distribution of the pain of lead colic over the whole abdomen, its paroxysmal character with the continual dull ache, its relief on pressure, the absence of rigidity and the blue line on the gums point definitely to lead poisoning. Other forms of colic, hepatic, renal and pancreatic, are characterized by extreme restlessness, the patient turning from one position to another, getting in and out of bed, which is quite unlike the rigid immobility of perforation. Tabetic crises are detected as soon as suspected, for the condition of the reflexes and pupils make the diagnosis clear; in fact, a small irregular pupil may arouse suspicion at the first glance. Intestinal obstruction and mesenteric thrombosis lack the rigidity of perforation, though the melæna of thrombosis may suggest a bleeding duodenal ulcer. The abdominal pain of Addison's disease occurs generally towards the end of the disease, when the asthenia, weak pulse and pigmentation are well marked. Those terrible attacks of pain, sometimes ending in sudden death, which are found occasionally to accompany a chronic duodenal ulcer that has eroded the head of the pancreas, are not associated with rigidity. The pain of embolism is referred to the involved organ, rigidity is not so marked and the cardiac signs will direct attention to the possibility of embolism.

Having decided that a perforation is present, it is necessary to determine whether it is gastric or duodenal. The relative frequency of the two make it at least four to one in favour of the duodenum. On the whole, the rigidity of gastric perforation and

the tenderness are about the mid-line or to the left of it, while in duodenal perforation they are to the right. The type of previous indigestion may assist also.

Treatment.—A diagnosis of perforation demands immediate operation. The operation will be considered under three headings:

(1) Incision.
(2) Condition found at operation.
(3) Methods of dealing with the perforation.

The incision may be made in the mid-line, or through the right *rectus abdominis,* or over the right rectus. The anterior layer of the rectus sheath having been opened, the muscle is retracted to the right and the peritoneum opened behind it. If the diagnosis points to a gastric perforation, it is better to open the abdomen in the mid-line or to the left of it. The surgeon will decide for himself the length of incision necessary for unhampered manipulation. In some cases, owing to mistaken diagnosis, the appendix has been tried and found not guilty and if a muscle-splitting incision has been made, a second one will be necessary, but if the incision for the appendix has been made through the rectus or its outer border, upward extension is all that is wanted.

The conditions found in the abdominal cavity vary. There may be some bubbling of gas on opening the peritoneum, but there is always free fluid, generally yellowish, or bile-stained, containing the flakes of lymph and perhaps food débris varying from carrots to orange pips; in one instance the fluid to my untutored nose suggested beer. The fluid in perforation of the duodenum collects around the gall bladder and duodenum, flows into the right kidney pouch and down the outer side of the ascending colon to the caecum; thence it passes the lateral and lower edge of the caecum into the pelvic cavity and this may contain much infective material, while the small intestine area is still unsoiled. In some cases the fluid overflows the transverse colon and involves the small intestine area, but it is still directed to the caecum by the obliquity of the mesentery and so again to the pelvis on the medial aspect of the caecum. In both paths the appendix may be soiled and is found smeared with lymph as if dipped in cream, but the infection is obviously of its peritoneal coat and not from within. These paths of descending infection have been worked out experimentally by Maynard-Smith.

In a perforation of a gastric ulcer the anterior wall or lesser curvature is usually involved and the fluid may be limited by the transverse colon or overflow to the small intestine. A perforated pyloric ulcer mimics a duodenal perforation. In one case the perforation of the stomach was into the lesser sac (omental bursa). Fluid from duodenal perforation does not seem to enter the *foramen epiploicum* (Winslow). In all the cases of this series the perforation, whether duodenal or gastric, occurred in a chronic ulcer and in one case in a carcinoma of the lesser curvature; so that as soon as the hand is passed into the abdomen the thickening around the ulcer can be felt. The perforation appears as a rounded puncture in an area whitened by a deposit of lymph and hardened by infiltration and œdema, so that the involved area often will not bend or infold and the appearance resembles a small hole worn in the sole of a shoe. In no case was more than one perforation encountered. Close inspection of some perforations shows a plug of lymph already sealing the opening.

The methods of dealing with the ulcer vary in the practice of different surgeons and may be classified roughly thus:

(1) Simple suture with or without drainage.
(2) Suture with a "patch" of omentum with or without drainage.
(3) Excision of the ulcer.
(4) Any of the above methods with a gastro-jejunostomy or other short circuiting operation.
(5) Merely draining the perforation by a tube, making an "external duodenal fistula."

The condition of the patient and his peritoneal cavity control the amount of operative interference. In a patient suffering from shock or advanced infection, closing the ulcer and drainage of the peritoneal cavity will be as much as is judicious. The closure of the ulcer may be difficult owing to its unyielding walls and the cutting out of the sutures; in such an event a patch of lesser omentum or of the right edge of greater omentum may be used and this has been found invariably to be water-tight. The question of performing a gastro-jejunostomy at the same time as closing a duodenal perforation is debatable. It depends largely on the duration of the perforation and therefore on the extent of the peritonitis. It was done in twelve cases with perforations varying in duration from a "few hours" to thirty-six hours. All the patients recovered. In those cases in which gastro-enterostomy is not carried out as part of the treatment of a perforation, it is better to do it some weeks later. This was done three times and the curative effect on the perforation was very striking, for in one case a few adhesions only disclosed the site of the ulcer. In all cases of suture, whether accompanied by a gastro-enterostomy or not, No. 1 plain catgut has been used, the short circuit being done in three layers and without clamps. Plain gut was adopted throughout, because it was noticed that when the suturing was effected with plain gut and was associated with drainage, leakage of intestinal contents had not occurred in a single instance.

Excision of the ulcer has not been practised in this series. In closing in a duodenal ulcer, if it be impossible to avoid undue narrowing of the lumen of the canal, gastro-enterostomy should be performed and if this procedure be contemplated from the first, it is as well to narrow the lumen even to obliteration. In one case a duodenal perforation was not closed, but merely drained by a tube, owing to the difficulty of suture and an "external duodenal fistula" was formed. This drained for two to three weeks and then closed and the patient recovered.

In this series six gastric perforations, all of the lesser curvature and one of a carcinomatous ulcer, are included. They were sutured and the abdomen drained; the patient with carcinoma died nine weeks later with secondary growths in the liver and above

the diaphragm. The peritoneal cavity should be cleansed gently, the fluid mopped up with sponges and special attention paid to Morison's kidney pouch, Washing out the peritoneum is not necessary and is, perhaps, dangerous. The question of drainage is decided by the condition present inside the abdomen and not by a quotation from a surgical master. In this series there has been a decreasing tendency to drain, for it was noticed that in the earlier cases which were drained, very little discharge passed through the tubes during the first forty-eight hours and by that time they were shut off from the peritoneal cavity and were useless. If left in too long, they act as foreign bodies and cause an offensive discharge, as is so often seen in tubes left unnecessarily long to drain an acute appendicitis. When the exudation is not shut off, but is free among the coils of intestines, it cannot be drained adequately by any tube or tubes and it must be dealt with by the peritoneum, which is anxious to assist if not unduly insulted. Nor is all this exudation dangerous; it may be a line of defence. A definite collection of pus in a cavity with walls made firm by lymph deposit needs draining, because the walls do not collapse immediately the pus is evacuated. When drainage was used, it was established by rubber tubes without gauze, which ought not to be placed near the site of the perforation, if it be used. In only one instance was a tube put into the pelvis. No other method of short circuiting than posterior gastro-enterostomy was adopted.

The after treatment is simple. The patient is put in the Fowler position and injections of saline solution are given by the rectum. Fluid is given by the mouth as soon as the vomiting ceases, either water, whey, barley water or albumin water, and the diet is gradually increased by the addition of milk, broths, beef tea, junket, jelly, etc., till on the seventh or eighth day fish or chicken are allowed. An alkaline mixture is given three times a day.

The results of operation for perforated ulcers depend upon the duration of the perforation and this factor is often beyond the control of the surgeon, so that statistics are determined partly by chance. Any surgeon whose statistics are good, has had the elements of luck on his side. In this list there were six patients with gastric ulcer of whom five recovered and one, the subject of malignant disease, died nine weeks later with metastases in her liver, after having had a subphrenic abscess drained in the meantime. Of the nineteen patients with duodenal perforation, all recovered. Twelve of these had a gastro-jejunostomy done at the same time. The sex of the patients is interesting; three in the six gastric series were females and all in the duodenal series were males.

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(9) Osler—"Principles and Practice of Medicine."
(10) Oxford—"Surgery," Vol. II., p. 588.
(11) Rose and Carless—"Manual of Surgery."
(12) Russell, Wallace and Box—*St. Thomas's Hosp. Rep.*, 1897 (Peritoneal Watersheds).
(13) Rutherford Morison—*British Medical Journal*, 1894, Vol. II., p. 968 (Morison's Pouch).
(14) Thomson and Miles—"Manual of Surgery," pp. 446 and 462.

Details of Cases.

Name.	Sex.	Age.	Previous Symptoms.	Duration of Perforation.	Provisional Diagnosis.	Treatment.	Result.
S.W.	M.	45	Pain 1½ hours after food for 3 months; hæmatemesis and melæna	12 hours	Ruptured ulcer ? gastric	Perforation on lesser curvature; suture with gut; tube in side	Recovery
A.S.	F.	33	Pain just after meals for 4 months; one attack of hæmatemesis; being treated in hospital	2 hours	Ruptured gastric ulcer	Perforation of lesser curvature; ulcer patched with lesser omentum; lesser sac drained	Recovery
E.S.	F.	30	Quite well till 8 days ago, when sudden pain in epigastrium, followed by vomiting, which, with pain, has remained since	8 days	Ruptured gastric ulcer	Pus found in left subphrenic region; drained by tube	Recovery
J.G.	M.	38	Pain just after food for indefinite period; walked to hospital two nights ago with severe abdominal pain after eating tinned fish	48 hours	Acute appendicitis	Appendix removed, but not the cause; stomach found perforated at lesser curvature; sutured and patched; drain in side and pelvis	Recovery
F.D.	M.	50	Severe abdominal pain for one day	24 hours	Ruptured ulcer	Perforation of posterior wall of stomach; sutured and drained	Recovery
E.L.	F.	47	"Dyspepsia" for some years; treated in a hospital for six weeks; losing weight	4 hours	Ruptured ulcer	Perforation of malignant ulcers of lesser curvature; nodules in liver; suture and drainage; later drainage of subphrenic abscess; death nine weeks after operation; infection of both pleural cavities; nodules in liver	Death

(Continued on next page.)

Details of Cases—*Continued.*

Name.	Sex.	Age.	Previous Symptoms.	Duration of Perforation.	Provisional Diagnosis.	Treatment.	Result.
J.A.	M.	38	For some weeks nagging pain in abdomen some hours after food, waking him from sleep; no vomiting	5 hours	Perforated duodenal ulcer	Perforation on anterior wall of first part of duodenum; sutured; five weeks later posterior gastro-enterostomy; few adhesions only at site of ulcer	Recovery
J.V.	M.	41	Severe pain 12 hours previously	12 hours	Acute appendicitis	Appendix found innocent; small perforation just beyond pylorus; sewn over and posterior gastro-enterostomy; drainage by stab wound in side	Recovery
J.P.	M.	41	"Indigestion for a long time"	?	Ruptured duodenal ulcer	Ulcer of first part of duodenum perforated; sutured and patched and drained	Recovery
J.D.	M.	62	?	?	Perforated duodenal ulcer	Perforation half an inch from pylorus; sutured and posterior gastro-enterostomy; no drainage	Recovery
E.W.	F.	30	?	?	Perforated duodenal ulcer	Suture; posterior gastro-enterostomy; no drainage	Recovery
J.O.	M.	56	Sudden pain while swinging a hammer	Few hours	Perforated duodenal ulcer	Ulcer sutured; posterior gastro-enterostomy; no drainage	Recovery
B.O.	M.	45	Previously treated for lead colic; sudden abdominal pains 36 hours before operation	36 hours	Acute appendicitis	Appendix removed (innocent); ulcer of duodenum sutured; drainage	Recovery
F.P.	M.	38	Fullness and pain half an hour after meals for some months; has vomited; sudden pain five hours before admission	5 hours	Ruptured duodenal ulcer	Ulcer of duodenum sutured; drainage; posterior gastro - enterostomy five weeks later	Recovery
T.P.	M.	57	Two days ago sudden pain and collapse	2 days	Ruptured duodenal ulcer	Perforation of first part; unable to stitch; tube passed down to perforation; food leaked through opening, which gradually closed; two months later gastro-enterostomy; few adhesions only at site of ulcer	Recovery
J.E.	M.	44	Severe epigastric pain two hours after meals	10 hours	Acute appendicitis	Appendix removed, but not the cause; perforation of anterior surface of duodenum 1.25 cm. from pylorus; suture and drainage; four weeks later posterior gastro-enterostomy	Recovery
J.L.	M.	42	———	—	Perforated duodenal ulcer	Perforation of first part; suture; posterior gastro-enterostomy; drainage	Recovery
M.P.	M.	62	Admitted under influence of alcohol	?	Perforated duodenal ulcer	Perforation 2.5 cm. from pylorus; sutured; drained through stab wound	Recovery
G.W.	M.	48	Treated in hospital for duodenal ulcer for two months	?	Perforated duodenal ulcer	Perforation half an inch from pylorus sutured and "patched"; posterior gastro - enterostomy; no drainage	Recovery
F.B.	M.	20	Pain "some time" after eating for months	4 hours	Perforated duodenal ulcer	Perforation of first part; suture of perforation; posterior gastro-enterostomy; no drainage	Recovery
C.M.	M.	43	No history of indigestion	2 days	Perforated duodenal ulcer	Perforation of first part; suture of perforation; posterior gastro-enterostomy; no drainage	Recovery
G.J.	M.	21	Pain some time after eating for some weeks	2 hours	Perforated duodenal ulcer	Perforation of first part; suture of perforation; posterior gastro-enterostomy; no drainage	Recovery
B.C.	M.	43	For ten years pain after eating	5 hours	Ruptured duodenal ulcer	Suturing of ulcer; posterior gastro - enterostomy; no drainage; perforated on first part	Recovery
W.V.	M.	25	Pain in epigastrium for one week; came some time after food	12 hours	Ruptured duodenal ulcer	Perforation of first part; sutured; posterior gastro - enterostomy; no drainage	Recovery
J.Mc.	M.	28	Indigestion for one year	9 hours	Acute appendicitis	Appendix removed, but not the cause; perforation of first part of duodenum; sutured; posterior gastro-enterostomy; no drainage	Recovery

Results.—A. Gastric Ulcers: Six cases: five recoveries; one death in case of malignant disease.
B. Duodenal Ulcers: Nineteen cases: no deaths.

Unfortunately, the notes of some of the cases have not been written up carefully, because many of the cases were "urgents" in the middle of the night.

Reviews.

HISTOLOGY.

A book which has been before students for 35 years and has passed through eleven editions, does not require any praise, for its merits are well known to the majority of medical men. The eleventh edition of Sir E. Sharpey Shafer's "Essentials of Histology"[1] has recently appeared and the alterations from the tenth edition, which appeared in 1916, are few and for the most part unimportant. There are some alterations in the text, but these are mostly in the direction of making points clearer; there is not much new matter. A few of the illustrations have been replaced by new ones, generally with advantage.

The book remains the best text-book on histology available for students; but, like so many other books which have gone through a number of editions, it is becoming too large and too detailed for the average medical student. As previously, the subject matter of the book is divided into fifty lessons and there is an appendix giving full directions for the preserving and staining of material for histological examination.

SYPHILIS.

The first edition of Dr. K. K. Chatterji's book on syphilis in general practice is an excellent handbook of 332 pages, with bibliograph and index.[2] The book opens with a short historical account of the disease syphilis. The two succeeding chapters deal with the social and national aspects of syphilis and syphilis in relation to marriage. The microbiology of syphilis and its general pathology are briefly described.

The clinical course of the disease in each phase of the disease has been carefully and thoroughly described. The diagnosis and differential diagnosis have not been overlooked.

In two chapters the author deals with his original research work; in Chapter XXIII. he describes the margosate precipitate test for syphilis and in Chapter XXVI. treatment by margosatis.

The modern methods of treatment by salvarsan and its substitutes, combined with mercury, are carefully described.

The book will be found by the busy practitioner to be admirably suited to his needs. It contains full information concerning syphilis, its diagnosis, differential diagnosis and treatment, carefully described in as few words as possible. There is a complete absence of padding, a rare virtue in a book of this kind. The work contains numerous illustrations and many coloured plates which should be of use to the general practitioner.

THE AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY.

The American Journal of Obstetrics and of Diseases of Children has been replaced by a new publication called *The American Journal of Obstetrics and Gynecology*. This publication is produced under the direction of an editorial board of thirty-three of the leading obstetricians and gynæcologists of the United States. The Editor is Dr. Geo. W. Kosmak and the Associat Editor, who has charge of the department of reviews and abstracts, is Dr. Hugo Ehrenfest. The journal is to be published monthly and the annual subscription outside the United States is $6.40. The agents in Australia are Messrs. Stirling & Company, of Melbourne, through whom subscriptions can be arranged. We have received Number 1 of Volume I., dated October, 1920. It is well printed on good paper and the illustrations are well reproduced.

The Editors are to be congratulated on the admirable selection of material in the first issue and on the manner in which this material is presented. If the standard set is maintained, the journal has a secure future as one of the leading journals of its kind in the world. It is said to be a journal conducted by the profession for the profession. Its policy will be determined by the editorial board and the editorial utterances should therefore be authoritative. The first issue contains six original articles, including a thoughtful address delivered by the President of the American Gynecological Society, Dr. Robert L. Dickinson, an article on the transition stages from benign to malignant conditions in the ovary by Dr. T. Watts Eden and Dr. Gorden Ley, one on induction of labour at term by Dr. Charles B. Reed, one on the prophylactic forceps operation by Dr. J. B. De Lee, a fifth on extra-uterine Cæsarian section by Dr. John A. McGlinn and the sixth on cranial and intra-cranial birth injuries by Dr. Harold Bailey. All these articles are of a high order.

The second part of the journal is devoted to a record of the proceedings of the American Gynecological Society. The discussions are given *verbatim*. The didactic value of these records is considerable. Finally, there is the department of reviews and abstracts. An admirable collective review on the prophylaxis and treatment of puerperal infections has been contributed by the Associate Editor. This is followed by a small number of good abstracts of articles which have appeared in other medical journals. General practitioners and those who confine their practice to obstetrics and gynæcology, will find the 112 pages of the first issue full of instructive material. Judged from this issue, we can recommend everyone to take this new and excellent journal.

[1] The Essentials of Histology, Descriptive and Practical, For the Use of Students, by Sir E. S. Shafer, F.R.S.; Eleventh Edition; 1920. London: Longmans, Green & Company; Demy 8vo., pp. 577, with 720 illustrations. Price, 14s. net.

[2] Syphilis in General Practice, with Special Reference to the Tropics, by K. K. Chatterji, F.R.C.S.E., with an Introduction by W. D. Sutherland, C.I.E., M.D.; 1920. Sydney: Butterworth & Company (Australia), Ltd.; Demy 8vo., pp. 332, with 56 original illustrations. Price, 18s. net.

Naval and Military.

APPOINTMENTS.

It is announced in the *Commonwealth of Australia Gazette*, No. 110, of December 16, 1920, that the appointments of the following officers in the Australian Imperial Force have been terminated:

Second Military District.

Lieutenant-Colonel R. Fowler, O.B.E., 8th September, 1920.
Captain A. Braby, 5th November, 1920.
Captain A. L. McLean, M.C., 18th October, 1920.

Third Military District.

Captain C. H. Leedman, M.C., 10th July, 1919.
Captain R. Howden, 19th January, 1917.
Captain R. T. Fetherstonhaugh, 29th October, 1919.
Captain J. R. Harris, 13th August, 1919.
Captain M. H. O'Sullivan, 21st August, 1919.

Fourth Military District.

Major W. J. E. Phillips, M.C., 19th October, 1920.

The following notices concerning the granting of substantive rank to medical officers holding honorary commissions on the Reserve of Officers has been published in the *Commonwealth of Australia Gazette*, No. 113, of December 23, 1920. All these appointments are dated October 1, 1920.

Fourth Military District.

The undermentioned Honorary Lieutenant-Colonel to be Lieutenant-Colonel:—

Henry Simpson Newland, D.S.O.,

The undermentioned Honorary Majors to be Majors:—

Hugh Herbert Montgomery.
Edgar Jabez Brown.
Malcolm Leslie Scott.
Wentworth Roland Caneagh Mainwaring.
Lancelot Alfred Hayward.
Frederick Lawrence Wall, M.C.,
Elliott Arthur Brummitt.
Charles Halliley Kellaway, M.C..

The undermentioned Honorary Captains to be Captains:—

John Howard Leon.
Arthur Goode.
Edward Brooke Thomas.
George Mervyn Hay.
Ralph Alderton Baker.

The Medical Journal of Australia.

SATURDAY, JANUARY 1, 1921.

A Retrospect.

(I.)

Twelve months ago the first place was given in our annual survey of the year's work and of the year's progress to the problems connected with the return of the Empire to peace. There were many duties half fulfilled and many tasks just begun in the process of the transition from the state of war to that of ordinary life. During the year that is now ending the last of those who left our shores to serve in the armies of the Empire, have returned and have resumed their former duties as civilian practitioners. The Australian Imperial Force is all but non-existent. A large number have retained military rank as medical officers in the Australian Military Forces. A few are still performing military duties with the permanent forces. There has been some talk about the reconstruction of the Australian Army Medical Corps, but, as far as we are aware, the reformation has not emerged from its preliminary stages. A committee has been appointed to consider the requirements of the medical services and to prepare a scheme on which may be based an efficient and ever-ready Army Medical Corps. We have pointed out on one or two occasions that one of the essentials for smooth working and maximal utility in time of need would be that the Director-General of Medical Services should be directly responsible to the Minister of Defence and should report on all matters of importance personally to him, not through the intermediation of the Adjutant-General. In the next place, the status and emoluments of the Director-General of Medical Services should be in keeping with the importance of his high position and his grave responsibility. The next war must not find us unprepared. During peace time the service must be kept in a condition of efficiency and activity. Experience, even that bought at the dear price of blood, is soon forgotten. Our Army Medical Corps must be guided by a man of exceptional ability and determination. Such a man is worthy of a high wage. His rank must be equal to that of the responsible heads of the other essential branches of the Army. The third requirement for the future service is a relatively large permanent force of medical officers. Some system should be devised in order that the back-bone of the service should be composed of highly trained, scientific practitioners and competent officers. The old order of military affairs, with its proverbial inertia and unjustified sense of superiority, must give way to a spirit of progressiveness and competence.

Closely connected with this question is that of the care of discharged soldiers who bear the marks of active service in the form of some disabling physical injury or progressive disease. The medical profession has lent its aid in the endeavour to restore to health and working capacity all those who have returned to Australia incapacitated from war service. Good progress has been made in the arrangements for the treatment of ex-service men suffering from tuberculosis, while the neurasthenic and psychasthenic men are receiving admirable treatment. It has not been easy to give to our returned soldiers all the advantages which modern science has to offer. Part of the defect lies in the cumbersome organization of the Department of Repatriation. Part lies in the fact that many of the disabled men passed out of the hands of the Defence Department before full advantage had been taken of the restorative measures available.

The Trustees of the Medical Officers' Relief Fund have recently published in these columns a justification of the Fund and have shown how valuable has been the aid that they have been able to extend to the dependants of our fallen colleagues, to incapacitated men and to returned medical officers who were in need of assistance to enable them to re-establish themselves in civil practice.

The Passing of the Australasian Medical Congress.

The eleventh and last session of the Australasian Medical Congress was held in Brisbane in August. The institution, which had come into existence thirty-three years ago, has served its purpose and has now gone into voluntary liquidation. The ballot on the question whether the Congress should be abolished in order that the Australasian Branches of the British Medical Association might be given an opportunity to establish a congress has been answered in the

affirmative by a large majority. A great deal of space has been devoted in this journal to the Congress. A brief history of its evolution, development and achievements has been published and for the first time a full summary of the proceedings has been published in a medical journal. The discussions in the sections were of a high order. With few exceptions the communications were of the nature of records of experience rather than announcements of original discoveries. The practical value of many of these interim reports is considerable. We propose to publish *in extenso* a few selected papers. The volume of the proceedings will appear in due course.

A full dress discussion on the problem of the possibility of the development of tropical Australia by a white race formed the most attractive item on the programme. It stands as a debate of unusual excellence. Many of the speeches may be classed as expressions of opinion and records of scientific facts, clothed in well-chosen terms, of rare merit. Dr. J. H. L. Cumpston, Dr. A. Breinl, Professor W. Osborne and Dr. T. A. Nisbet, the four selected speakers, Dr. T. G. Ross, Dr. R. A. Macleod, Sir James Barrett and Professor H. Priestley may be congratulated on the excellence of their contributions to a very difficult and at present scientifically insoluble problem. That the outcome of the debate should have been the adoption of some very enterprising resolutions is gratifying, inasmuch as the solution can only be brought appreciably nearer by the practical demonstration of a tropical Australia, run on scientific hygienic principles, populated by a healthy race of white men and women. The debate should close the long chapter of wordy warfare. There is work to be done, sanitary principles to be applied, communications to be opened up, hygienic habits to be inculcated. The hygienist is not responsible for the economic difficulties that have to be overcome in the establishment of industrial life of the white man in the tropics. He has no concern with the problem of the relative attraction of the north and the south to the worker. If the captains of our industries find that, notwithstanding the demonstration that white men and women can live and work in the north and yet remain healthy, the cost of production is so high that competition with other countries becomes impossible, they must blame the misleaders of labour for having introduced a policy into the Commonwealth which places immediate personal advancement before the good of the country. The physiologist, the hygienist, the physician has each expressed the guarded opinion that the experiment to render the tropical areas of Queensland healthy and fit for the labour of the white man is worthy of a serious trial. This opinion has been supported by the belief that the experiment will prove successful, if it can be carried out with scientific skill and thoroughness. One essential must be guaranteed. If the country is prepared for the healthy and happy development of the white worker, the white idler, the unpatriotic drone must be excluded from the scheme. No country, be it in the tropics, sub-tropics or temperate zone, can hope for commercial prosperity unless its inhabitants are prepared to exhibit industry and reasonable efficiency.

Preventive and Curative Medicine.

The public is gradually awakening to a realization of the possibility of greater achievements in the realm of preventive medicine than in the past. In Great Britain the establishment of the Ministry of Health has paved the way for a reform of considerable magnitude. The fundamental ideas of this scheme are not new. They have found expression in various forms during the past ten or twenty years. For the first time, however, the public has been able to grasp the significance of a co-ordinated effort to eradicate disease by attacking it at its source and by applying the basic principles of hygiene and preventive medicine in the homes of the people. Sir George Newman's masterly report stands to-day as the classic on which future endeavour will be based. We have called attention in these columns to the importance of keeping the work of preventing distinct from that of endeavouring to cure disease. In Australia we are on the eve of a reform and may learn much from the doctrines and experiences of our colleagues in the United Kingdom. It is, nevertheless, essential that we shall proceed circumspectly and critically. One clause of our creed must be that the intervention of third parties between the private practitioner and his patients must be opposed in the interests of the patients.

Our public health system remains intrinsically un-

altered, notwithstanding the legislative modifications that have been introduced in recent times. Departmental lethargy must give room to co-ordinated activity. That the future has better things in store for Australia is evident from the rustle in the groves of the Federal encampment. There is talk of the institution of a Federal Ministry of Health, with the object of achieving uniformity of action and increased efficiency in all the State health services. The signal success of the Australian Hookworm Campaign, the vigilance of the quarantine department, the value of the assistance extended to the State Governments by the Federal Government in the combating of venereal disease and tuberculosis are indications that if such a ministry be established it will serve the Commonwealth faithfully and well.

The British Medical Association.

The most important events in the internal arrangements of the British Medical Association during the year 1920 have been the preparations for the admission of incorporated bodies and other societies of medical practitioners to membership of the Association and the increase in the subscriptions of members. We have dealt on several occasions with the imperative necessity for caution and alertness in the drafting of the new Articles and By-laws needed to give effect to the proposed change in the constitution of the Association. In the first place, the several Branches will have to formulate in unambiguous terms their requirements in regard to their own domestic management. The change aims at giving greater autonomic power to the overseas Branches. No emissary can possibly safeguard the interests of the six Branches in Australia unless he is informed by each which of the functions of the parent body it desires to perform and in what way it is proposed to attain the various objects for which the Association exists. The Branches, or at least a majority of them, are in favour of sending a special representative to London to attend the conference at which the modifications of the Articles will be discussed. We understand that the Federal Committee is prepared to nominate a representative who possesses all the qualifications necessary for the advantageous and skilful performance of this difficult task. If his mission be successfully completed, the Australian Branches of the British Medical Association will be placed under a very considerable indebtedness to him.

The question of the increased subscription is not a serious matter. Everything has become dear. The members of the British Medical Association are receiving more for their annual subscription than they have received in past years. Surely they cannot object to a small increase in the amount to be paid for the organization that has profoundly improved the practice of medicine. The regulation of lodge practice under conditions rendered uniform by recognized standard terms of contract has resulted in a material gain to the individual practitioner in regard to both remuneration and general conditions of work. Members of the British Medical Association enjoy immense advantages as the result of the power of this organization in protecting their interests, while safeguarding the common weal. It is unwise for anyone who is eligible for membership, to stand outside. The subscription is small, actually and relatively. If the Branches would agree to make the amount of the annual subscription the same in all the States, the position would be more logical.

The Federal Committee of the British Medical Association in Australia has undertaken to organize periodical medical congresses for the Branches of the Association in Australia and has invited the New Zealand Branch to co-operate, in order to preserve the Australasian character of the congresses. No steps have yet been taken to evolve a programme or to devise the details of the machinery needed for a periodical meeting of the medical profession.

Records have been published of the work achieved by the Federal Committee and by the six Branches of the British Medical Association in Australia throughout the year. Much of this work is of importance to the profession. In almost every case the medico-political, ethical and organization work of the Branches has increased enormously. The details are of interest and significance to every member, but only those who take part in the deliberations, can master these details completely. Expansion of activity and the creation of fresh machinery will probably result from the determinations of the conference to be held in England this year. It is not un-

likely that a better scheme for central control will be evolved and that there may be created a Federal Council, with powers of initiation and execution.

Medical Education.

Vast changes have come over the medical schools of the Commonwealth during the twelve months just ended. The death of the great founder of the Medical School of the University of Sydney, Thomas Anderson Stuart, on the last day of February was soon followed by the departure for another sphere of activity of his co-worker and colleague of many years, Professor J. T. Wilson. The founding of the Chair of Medicine in 1919 led logically to the foundation of the Chair of Surgery. Sydney University is most favourably placed by having men of eminence and admitted ability to fill both these new chairs. We have expressed especial gratification that both Professor A. E. Mills and Professor F. P. Sandes are graduates of the University in which they hold these high positions. Temporary arrangements have been made for the continuance of the work in the department of anatomy. It is an open secret that the University authorities are desirous of securing at some future date the services of a brilliant young anatomist, Dr. J. I. Hunter, as successor of Professor Wilson. The tempering influence of time will permit the excellent qualities of this Australian graduate to mature and the Medical School will ultimately reap the benefit of having five Sydney graduates holding the positions of professors. The latest change is the appointment of Professor Chapman to the Chair of Physiology, a position for which he had many years of apprenticeship, and of Dr. H. Priestley to the position of Associate Professor of Physiology. No changes of a similar kind have occurred in either the University of Melbourne or the University of Adelaide. Of the recent appointment of Professors Wood-Jones, Brailsford Robertson and J. B. Cleland mention was made a year ago.

The Medical Faculties in Australia, as elsewhere in the Empire, have considered seriously and with deliberation the overdue changes in the medical curriculum. An important conference of representatives of all the Australasian Universities with Medical Faculties was held in Sydney in the month of September. More recently the first session of the Advisory Committee appointed at the conference has continued the deliberations then begun. In the meantime, the Faculties individually have given these matters uninterrupted attention. Progress has been registered and it would seem as if many of the changes which we have advocated in these columns, will be introduced in the near future. It is noticeable that the principles established by the members of the Pathological Club of Edinburgh have created a profound effect on the minds of those responsible for medical education in Australia.

THE ORIGIN OF CANCER.

Theories concerning the origin and causation of cancer are legion. During the course of a half of a century and more observers, experimenters and dreamers have put forward hypotheses with surprising rapidity and at times with considerable ingenuity. One after another these suggestions have been relegated to the scrap heap of mistakes. Parasites have been described often enough. In some instances the suppositious organism was shown to be either an artefact or some extraneous substance or else an abnormal portion of a body cell. In others the organism demonstrated had no causal connexion with the malignant process. Then there was the compromise according to which the cancer cell itself, having evolved a state of existence foreign to the normal physiology of the body, was regarded as a parasitic unit. In a parallel series of hypotheses the disturbance of the cell was made the starting point and its newly acquired property of limitless growth without ascertainable physiological activity was made the end point. Some of the views put forward were based on careful study and actually offered a reasonable explanation for some of the observed facts. But none were wholly acceptable and all have been refused after mature consideration. Lastly came the chemical explanations. A few were based on bio-chemical reactions determined in the course of special investigations. Their ultimate failure was due to the fact that the micro-chemistry of the cancer cell and of the cancerous growth has not been completely discovered. A close study of the literature of the subject leads the critical student to the conclusion that the solution of the problem will not be found in the imagination of the arm chair philosopher nor in the results of the hustler who conceives a hypothesis and proceeds to prove it experimentally. A vast amount of experimental work must be accomplished before all the ascertainable facts can be marshalled. The facts must be known before an acceptable explanation can be devised.

Dr. Alexander Paine, who has been working steadily at the subject of the ætiology of cancer for many years at the Research Institute attached to the Cancer Hospital in Fulham Road, London, has recently published his views concerning the origin of cancer.[1]

[1] *The Lancet*, October 2, 1920.

It may be stated at once that his explanation appears to be based on careful observation and, as far as it goes, may be regarded as probably correct. It fails, however, as all other explanations previously put forward have failed, in that the ætiological factor which determines the difference between an inflammatory and a malignant tumour is still unknown. Dr. Paine regards cancer as a disordered growth of epithelium caused by various physical or chemical irritants, the most important being the toxins of micro-organisms. He shows that cancer has an almost universal distribution throughout the animal and possibly the vegetable kingdom. He traces the histological changes in the common precursor of cancer, namely, chronic inflammation, and demonstrates that malignant degeneration does not supervene on the proliferative stages of inflammation, but arises first when the involved tissue is undergoing destruction. When the inflammation is not highly active, the epithelial cells are damaged. The nuclei stain badly and they exhibit other indications of structural alteration. The cytoplasm swells and becomes less dense than the cytoplasm of a healthy cell. These altered cells in an inflamed breast tubule are thrown off into the centre of the tube and may either die or survive as damaged cells. Dr. Paine has histological evidence in support of his contention that these damaged survivors eventually reveal peculiar characters, similar to those of embryonic cells. Mitoses appear; the cells begin to divide, to proliferate and to invade the adjacent lymphatic sinuses. In short, he holds the cancer cell is evolved from the damaged cell of a chronic inflammatory process affecting glandular or other epithelium. He shows that at times an inflammatory lesion of the breast may lead to innocent growths of various kinds in addition to malignant changes. He describes and illustrates an example of this, in which a breast affected with chronic mastitis was found to contain cystic adenoma, intra-cystic papilloma, fibro-adenoma and scirrhus carcinoma. He considers that the histological evidence is conclusive that all four types of growth had the same inflammatory basis of origin, which arose under the same stimulus.

This hypothesis is based on the assumption that an inflammatory tissue reaction invariably precedes the development of a malignant growth. Moreover, it appears to indicate that the ancestors of all malignant cells are highly differentiated cells which have become debased to lower types by the changes resulting from the damage. Dr. Paine does not suggest the origin of the spindle or round cells of sarcomata. He recognizes that inflammation may result from local infections, from local injuries, such as a contusion, from the chemical action of irritants, such as pitch, soot, petroleum, heat or X-rays. In the course of his investigation he found repeatedly that the breasts of mice revealing cancerous growths were involved in a bacterial inflammation. He has something to say concerning the cells themselves, which are prone to become implicated in a cancerous process. Young, actively physiological cells are usually endowed with the power of resistance and repair. When attacked by an inflammatory lesion, they are able to throw off the pernicious effects of the inflammation. It is essentially the senile cells that fall a prey to these changes. In this connexion he is careful to remind his readers that senility depends in part on the physiological life of any given cell. Bashford has shown that the chorion has a short life and that chorion-epithelioma appears at a time which corresponds to the senile stage of proliferation. The signs of senescence appear early in some individuals and late in others. Apparently the anticipation of tissue senility occurs in families. Dr. Paine endeavours to explain the hereditary predisposition to cancer by an assumption of a premature growing old of certain tissues. In the last place, he seeks and finds evidence satisfactory to himself to support the hypothesis that the damage inflicted by an insidious inflammation on epithelial and other highly differentiated structures attacks firstly and most profoundly the most delicate and functionally most important constituent of the cell, the nucleus. He has no direct evidence of the manner in which the chemical or mechanical irritant acts to bring about the peculiar and essential changes of cancer in the cell, nor has he any explanation to offer of the fact that chronic inflammation and presumably permanent damage to epithelial cells resulting from this inflammatory process are infinitely commoner than epithelioma.

FRIENDLY SOCIETY LODGE PRACTICE.

The Common Form of Agreement in New South Wales.

The Council of the New South Wales Branch of the British Medical Association, having ascertained the views of the medical officers of lodges throughout the State at the annual meeting of the delegates of the local associations of members with the Council, held on October 1, 1920, has now completed its negotiations with the friendly societies on the question of increasing the income limits which determine the right of lodge members and their dependants to the medical benefit of the lodge and the question of increased rates of remuneration for attendance. Finality was reached on December 20, 1920, at a meeting of the Medical Politics Committee of the Council with three representatives of the friendly societies duly accredited and empowered to act on behalf of all the orders.

The new terms will come into operation on April 1, 1921. They are as follows:—

(1) The prescribed income limits to be £260 and £364, instead of £208 and £312 respectively as heretofore.

(2) The prescribed minimum rates to be:—

(*a*) For medical attendance only—

In Sydney metropolitan area 26s., instead of 21s. (19s. in certain cases) as heretofore;

Outside Sydney metropolitan area 32s., instead of 26s. as heretofore.

(*b*) For medical attendance and medicine—

Outside Sydney metropolitan area 44s., instead of 34s. as heretofore.

(3) The fees for attending wives of members in their confinement and in cases of premature birth or miscarriage to be increased by £1 1s., making the minimum fee £3 3s., instead of £2 2s. as heretofore.

The lodges throughout the State are being notified of the new terms by the grand secretaries of their respective orders with a view to the contributions payable by the lodge members being adjusted to meet the new rates. The medical officers of lodges will be communicated with by the Council of the New South Wales Branch at an early date. It is understood that the necessary amendments of the existing agreements between the medical officers and the lodges will be effected by endorsement or in some other suitable way. The friendly societies have intimated that in the course of the coming year they will submit proposals for certain minor amendments of the agreement.

Abstracts from Current Medical Literature.

MEDICINE.

(1) Diabetes Insipidus.

A. A. Goldsmith and D. G. Sutton state that there has been some confusion in differentiating *diabetes insipidus* from other conditions accompanied by polyuria. In a number of mental conditions polydipsia occurs and this is naturally accompanied by an increased output of urine (*Illinois Med. Journ.*, June, 1920). The history of a case is recorded, ascribed to some trouble in the pituitary gland, probably of the nature of a hypo-pituitarism. Meyer classifies the polyurias as follows: (*a*) primary polydipsia, which occurs in the insane and also in hysteria; (*b*) primary polyuria, under which is classified true *diabetes insipidus*. Of the latter there are two varieties, the idiopathic and the central. *Diabetes insipidus* of central origin may be caused by cerebro-spinal lues, cerebral tumours, especially of the hypophysis, meningitis and trauma. In the differential diagnosis of polyuria it is necessary to rule out first of all *diabetes mellitus* and convalescent polyuria (such as occurs after enteric fever). Next, polyuria must be considered due to some anatomical lesion, such as contracted kidney, pyelitis, tuberculous kidney, urinary stasis, which may be due to a large prostate, or to the pressure of a uterine tumour. It is necessary to exclude certain nerve conditions, such as developmental troubles, disease of the glands of internal secretion, cerebro-spinal syphilis and psychic conditions. The polyuria due to the last named cause has a very great variation in the daily output of urine. In *diabetes insipidus* the urinary bladder may undergo a marked dilatation and it is not uncommon for a person suffering from this disease to pass as much as 500 to 800 c.cm. or even more at one time. With very marked distension there may be no discomfort. Various observers have suggested the following theories: (1) Lack of ability of the kidney to concentrate the urine. (2) A primary polydipsia occurs with a normal kidney function. (3) That it is a polyuria purely symptomatic in origin, produced by stimulation of the kidney by many causes. Engle thinks that it is a prolonged nerve stimulation, possibly in the medulla, which results in the stimulation in the glomeruli to a greater secretion, or inhibits the absorbing power of the tubules, or both. Stuben thinks that the condition may be an adrenalinæmia. Frank and Motzfeldt favour the pituitary gland as the seat of the trouble. Frank asserts that the condition is due to hypersecretion of this gland and Motzfeldt to a diminished secretion. Camus and Roussi were able to remove the pituitary body of dogs completely without the production of polyuria. Later, in the same experiment, by the production of a lesion in the floor of the third ventricle, they were able to bring about a prolonged polyuria. Eric Meyer points out that in experimental work on the pituitary body it is practically impossible to avoid injury to the sympathetic system. It is known that irritation to this set of nerves does produce polyuria. In regard to the prognosis of *diabetes insipidus*, it may be said that this is good in regard to life, but very poor in regard to ultimate recovery. In those cases of polyuria due to some determinable cause (such as urinary stasis), it is important to treat this cause. In certain cases of basilar syphilis an excellent recovery is brought about by appropriate treatment. In mental cases persuasion has been tried, but without much effect. Hypnosis has not been used often enough to allow conclusions. Diet is important and it may be necessary to omit foods which contain salt, or which produce urea, Meyer states that a vegetable diet tends to cut down the urine. After dieting for a time, the tolerance of the kidney seems to be raised. The majority of observers find that the patient improves on the administration of extract of the pituitary gland. It is stated that extract of the posterior lobes of six or seven glands tends to reduce the polyuria at night.

(2) Diagnosis of Heart Disease.

A. W. Hewlett contributes an article on recent advances in the diagnosis of heart disease (*Northwest Med.*, September, 1920). He describes the significance of cardiac murmurs. Less significance than formerly is now attached to systolic murmurs, but the significance of diastolic murmurs has not diminished. The murmur of aortic insufficiency is usually loudest in the third or fourth intercostal space close to the left border of the sternum. The murmur of mitral stenosis is notoriously variable. It may be louder in either the upright or recumbent position and frequently becomes louder after a little exercise. The differentiation of "irritable heart" or neuro-circulatory asthenia is discussed. Soldiers suffering from irritable heart frequently complain of breathlessness, pain about the heart on exertion, palpitation, dizziness and fainting. These symptoms often suggest a nervous origin. Definite cardiac enlargement is evidence of serious muscular change. Enlargement of the heart may escape detection by physical methods because a distension of the lung border overlying the heart separates this organ from the chest wall to an unusual degree. In elderly patients with emphysema of the lung borders, the apex beat may not be felt and the cardiac dulness may not be enlarged, even though radiographic examination shows an indisputable increase in the heart shadow. Accurate measurements of the heart shadow require an orthodiagraphic examination. Hypertrophy of the heart muscle is usually accompanied by some dilatation of its cavities. If one ventricle is hypertrophied to a greater degree than the other, this can be demonstrated by the electro-cardiograph. There are three common forms of disturbance of rhythm: (*i.*) the sinus irregularities, known as vagus, nervous or respiratory irregularities; (*ii.*) extra systoles and (*iii.*) auricular fibrillation. Auricular fibrillation is characterized by the fact that no succession of beats are equally spaced. It is absolute irregularity. When the rate is rapid and the irregularity extreme, auricular fibrillation is easily recognized. In some instances, however, the rate is not increased and the heart is almost, but not quite, regular. Such cases are difficult to recognize. Auricular fibrillation usually continues for long periods and has, therefore, been called the permanent irregularity. Yet it may occur in short paroxysms that last for hours or days and recur at intervals of months or years. Between the paroxysms the heart may appear to be perfectly normal. A very slow pulse below 40 usually means a complete heart block. The electro-cardiogram not only gives information concerning the relative weight of the two ventricles and the nature of an arrhythmia, but it may also give information as to the manner in which the cardiac muscle performs its contraction.

(3) Blocking of the Coronary Artery.

H. E. B. Pardee (*Arch. Int. Med.*, August, 1920) shows agreement in the electro-cardiographic findings between a clinically typical case of sudden blocking of a coronary branch and the experiments on dogs of both Eppinger and Rothberger and of Smith. The former injected silver nitrate into the deep left ventricular muscle; the latter tied the left branch of the coronary. In the patient's record, four hours after the sudden pain, a large T "mound" reversed in I., but not in II. and III., is seen to commence 0.006 of a second after the commencement of the ventricular complex. Lewis has shown that by 0.005 of a second all the ventricular muscle has entered contraction, with the exception of the basal part of the left ventricle. These phenomena, therefore, point to a hyperactivity of the muscle in the region of supply of the left coronary circumflex, due to anæmic necrosis. The next record, three days later, shows the development of left ventricular preponderance, and, along with succeeding records, the transition to a reversal of the directions of T, a definite fixed appearance remaining after a fortnight, large and pointed, but again changed in position. Four records were found in a search through 1,000 consecutive records for the latter appearance; the patients had suffered from precordial pain, acute in three instances and chronic in one. The conclusion is that if a finding typical of the latter occurs, there is a localized area of degeneration in the region indicated and, as coronary obstruction is the most frequent cause of this, the sign is "reasonably good" as an indication of a former coronary obstruction. This characteristic appearance is described, but comparison with both typical and atypical records, as presented in the original paper, is essential for comprehension.

NEUROLOGY.

(4) The Re-education of Hemiplegics.

Pierre Kouindjy, of Paris (*New York Med. Journ.*, May 22, 1920), presents anew his method for the treatment of hemiplegics by methodical massage and motor re-education, which has now had a 20 years' trial and has given most encouraging results. The paralysis of hemiplegics does not attack all of the muscles at the same time. Therefore, the first step is to make a systematic examination of the paralysed muscles; then, having determined the approximate tonicity of the various muscle groups and their antagonists, methodical massage is applied and is confined to those muscles which are hypotonic. There follow passive and active movements, of which the latter are the more important and must be most carefully directed, thus in re-educating the patient to walk, he is made to place the affected foot on the floor before the normal foot, which prevents dragging of the affected limb and also gives a more solid support. Such walking exercise is assisted by making the patient sit on chairs of varying height and elevating first his affected, then his unaffected limb on to the steps of a stairway or ladder in front. And re-education is further aided by the use of simple appliances, such as a double-inclined plane, a wheel chair, benches of different heights and so on. In a like way exercises and apparatus are applicable to the hemiplegic's arm. The reader is referred for details to a book by Kouindjy and Stragnell, entitled "Physiotherapy" and published in St. Louis.

(5) The Origin and Nature of Disseminated Sclerosis.

G. Marinesco (*Revue Neurol.*, 1919, XXVI.) reviews the case for an infective origin of disseminated sclerosis and argues that it consists primarily of an inflammatory process and that the cause is an infective agent. He asserts the belief that the virus reaches the central nervous system by way of the lymphatics. He cites in his support the early cell reaction in the adventitial sheaths of the veins. He also contends that the cerebro-spinal fluid is the vehicle for distribution. He refers first to the work of Kuhn and Steiner who succeeded by inoculations into rabbits and guinea-pigs of the cerebro-spinal fluid, blood, or a mixture of the two, in producing certain nervous symptoms, and who later, by examining the blood of infected animals with dark-ground illumination, found spirochætes resembling those of Weil's disease. He next quotes Siemerling's discovery, in 1918, of spirochætes resembling those of Kuhn and Steiner in the brain of a patient dying of disseminated sclerosis. Finally he reports these experiments of his own. The cerebro-spinal fluid of two patients with disseminated sclerosis selected from the Salpêtrière clinic, was injected into six guinea-pigs by intracerebral, intraperitoneal and intrathecal routes; of these, two inoculated intracerebrally showed three to four days later symptoms of paresis. The cerebro-spinal fluid obtained from them revealed many spirochætes of the type described by Kuhn and Steiner. Therefore, recent experimental work on disseminated sclerosis suggests the existence of a transmissible virus which is a specific spirochæte distinct from the *S. pallida*.

(6) Out-Patient Psychiatry.

Abraham Myerson (*Amer. Journ. of Insanity*, Vol. LXXVII., Part I.) gives a report of work in the psychopathic out-patient department of the Boston State Hospital. Of 1,577 patients, 131 were recommended for observation in wards, 128 for commitment to institutions for the feeble-minded, 26 to mental hospitals, 63 to general hospitals, 590 to out-patient care and the remaining 639 were dealt with in various ways. Females greatly outnumbered males, which is accounted for by the activity of social agencies (the Psychopathic Social Service) and the predominating number of female psycho-neurotics who attended of their own accord. The largest single group of cases was made up of backward children; then came cases of ordinary insanity, psychoneurosis, syphilis, delinquency and epilepsy. Among the special types of psychoneuroses, "the neurosis of the housewife" is given special mention; this might almost be called an occupation neurosis. Those who adopt an over-conscientious, over-critical attitude towards themselves form a small but interesting group. Interesting, also, are those cases of hysteria in which the patient manifests symptoms referable to his reaction to the disagreeable things in life. The observer thinks that the importance of heredity in producing feeble-mindedness has been over-estimated, because he finds that the major number of cases of feeble-mindedness occur in otherwise normal families. He also finds the number of feeble-minded delinquents less than he expected.

(7) The Psycho-Pathology of Alcoholism.

C. Stanford Read points out that we have been far too superficial in our pathological inquiries into many of the so-called alcoholic psychoses and that alcoholism is only contributory and more a result of the mental illness than the cause (*Journ. of Mental Science*, July, 1920). Alcohol is taken to promote the social instincts and to alleviate and narcotize the many mental conflicts to which we must all to some extent be victims. It thus becomes a psychological necessity in modern civilization. In excess it tends to destroy sublimation and aid mental regression and in this way may precipitate a psychosis. The regression may be of various degrees and may bring into conflict with the personality different impulses and desires previously more or less successfully repressed. Of these, the homosexual impulse is found on analysis to be the most frequent, the resulting conflict being very liable to result in paranoiac states. A deeper study of the so-called alcoholic hallucinoses and paranoid psychoses reveals psychogenic factors which should be looked upon as the real pathological basis of the abnormalities. Dipsomania most assuredly has a psychogenic basis. It must be noted, too, that with the aid of alcohol the *psyche* defends itself against mental pain, pleasure is gained by the freedom from inhibitions and compensations occur, though often at the expense of sanity. If these views are in any way true, many of these psychoses should be differently classified.

(8) The Histological Changes in Acute Chorea.

Pierre Marie and C. Trétianoff (*Rev. Neurologique*, No. 5, 1920) publish the results of an histological examination of the nervous system of a girl of 10 years, who died from chorea after an illness lasting six days. They found wide-spread inflammatory changes, chiefly affecting the basal ganglia and the *cortex cerebri* and diminishing in intensity in the direction of the mesencephalon. The process was of an irritative nature, characterized by an intense hyperæmia, a pronounced infiltration of the tissues by leucocytic cells and a proliferation of neuroglial elements. Degenerative changes were not distinctly evident. These changes differ from those of acute poliomyelitis (infantile paralysis), as in the latter disease the noble nervous elements specially suffer and the changes chiefly affect the bulb and spinal cord. For these reasons, also, chorea may be distinguished from encephalo-myelitis, induced by hydrophobia, tetanus and Landry's disease. The differentiation from encephalitis secondary to influenza, typhoid fever and certain infectious diseases, though less easy, is possible. The one disease which produces almost identical changes is *encephalitis lethargica*. In conclusion, they emphasize the point that there is a resemblance in the distribution of the changes with those described in chronic chorea and the chorea of Huntingdon.

(9) Chemical Analyses of Human Brains.

C. G. MacArthur and E. A. Doisy (*Amer. Journ. of Insanity*, October, 1919) analysed two human brains, one from a case of general paresis, the other from a supposed case of bulbar paralysis, giving a syphilitic history. In both the findings were essentially similar. The changes chiefly affected the lipins and extractives. Substances pertaining to medullated sheaths (cerebrosides) showed great loss. The phosphatids and sulphatids (lipoids of P. and S.) were reduced in amount. Both organic and inorganic extractives were relatively and absolutely increased. One would expect such changes in association with degeneration, provided it is the more complex structures which are altered to simpler compounds and but partly removed from the tissues.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on December 10, 1920, Sir David Hardie, the President, in the chair.

A vote of thanks was accorded to Dr. H T. S. Bell for having presented to the Branch two photographs of the original Brisbane General Hospital.

Annual Report.

The Honorary Secretary presented the annual report of the Council and moved that it be taken as read and adopted. The motion was seconded by Dr. A. C. F. Halford and was carried.

Annual Report of Council, 1920.

The Council has the honour to present the following Report of the work of the Branch for the year ended November 19, 1920.

Membership.

The Branch has now a membership of 300. During the year, 19 new members were elected, 33 transferred from other Branches, 16 transferred to other Branches, two resigned, ten struck off (unfinancial or left State and address unknown), seven died.

The Council regrets to record the following losses by death: Drs. J. V. Church, V. E. Collins, R. B. Huxtable, W. B. Nisbet, E. K. Overend, E. J. S. Spark, F. H. Thornton.

A hearty welcome home was extended to the following members, who have returned from active service during the year: Drs. J. G. Avery, E. Culpin, B. H. Hart, C. M. Lilley, E. S. Meyers, A. P. Murphy, A. T. H. Nisbet, N. G Sutton, M. G. Sutton, E. G. Thomson, V. N. B. Willis.

The metropolitan membership has again increased during the year. There are now 135 metropolitan members, compared with 116 in 1919.

Meetings.

General Meetings.—Eight ordinary monthly meetings and three special meetings were held, the average attendance being 29. As usual, no meeting was held in January, while, owing to the Australasian Medical Congress, the August and September meetings were cancelled. The special meetings were called for the following purposes: (*i.*) to consider the milk supply of Brisbane, in view of the proposed alteration in the delivery hours; (*ii.*) to consider the attitude of the Branch towards the *Liquor Referendum Act*; (*iii.*) to consider the proposals of the Council regarding alterations in the rules and by-laws concerning additions to the Council, increased subscriptions and advertising; also a minimum scale of fees. The October meeting was devoted to a discussion with the Odontological Society of Queensland. It was a great success and the opinion of those present was that similar meetings should be held in future.

Council Meetings.—The Council held 15 ordinary and 3 special meetings. The latter were held in connexion with a dispute over a sale of practice and a proposed colliery practice.

The attendance of members of the Council at the various meetings was as follows:

Sir David Hardie (President)	12
Dr. A. Sutton (Vice-President)	3
Dr. A. Graham Butler (Vice-President)	13
Dr. D. Gifford Croll (Honorary Treasurer)	14
Dr. R. Marshall Allan (Honorary Secretary) ..	16
Dr. D. A. Cameron (Honorary Librarian)	12
Dr. E. D. Ahern (Honorary Curator of Museum)	4
Dr. G. P. Dixon	12
Dr. J. Espie Dods	11
Dr. W. N. Robertson	8
Dr. A. H. Marks	17

The following is a list of papers which were read before the Branch during the year:

February 6.—Dr. E. A. Falkner (Toowoomba): "Medical Education: Some Points in Consideration Thereof."

March 5.—Drs. R. Graham Brown and Ellen Kent Hughes: "Tonsillectomy as a Means of Treatment of Diphtheria Carriers."

March 5.—Dr. V. N. B. Willis: "A Plea for a Standard of Cure in Cases of Gonorrhœal Urethritis in the Male."

April 19.—Dr. J. J. Power: "Blood Transfusion."

April 19.—Dr. R. Marshall Allan: "The Conservative Treatment of Eclampsia."

May 7.—Dr. Eustace Russell: "Blood Pressure."

May 7.—Dr. A. V. Meehan: "War Amputations of the Lower Limb."

May 7.—Dr. J. V. Duhig: "Vincent's Disease."

June 4.—Dr. J. G. Avery: "The Treatment of Gonorrhœa by the General Practitioner."

June 4.—Dr. T. H. R. Mathewson: "The Psychic Factor in Medical Practice."

July 2.—Dr. A. S. Roe: "Urinary Infections."

July 2.—Dr. J. B. McLean: "Bennett's Fracture."

October 1.—Dr. A. R. Menzies (Odontological Society): "The Treatment of Dental Abscess."

November 5.—Drs. E. D. Ahern, G. P. Dixon, S. F. McDonald, A. T. H. Nisbet and J. V. Duhig: "Cholecystitis."

Many interesting cases and specimens were exhibited at the various meetings. The Council notes with pleasure the high standards of the papers submitted, the increased attendance and the animated discussions following papers. They are indebted to the following sub-committee for the arrangements of the programme for the year: Drs. D. A. Cameron, E. D. Ahern and D. G. Croll.

Federal Committee.

Two Federal Committee meetings were held during the year. Drs. J. Lockhart Gibson and W. N. Robertson represented the Branch. Reports of the proceedings of the meetings will be found in the issues of *The Medical Journal of Australia* of February 14, 1920, and September 11, 1920.

Friendly Societies and Lodges.

Model Lodge Agreement.—Numerous inquiries have been made during the year for copies of the agreement, both by doctors and lodges. Several members have requested rulings on obscure points. After correspondence with the Hibernian Australian Catholic Benefit Society on the financial clauses, they were advised to meet their doctors in conference. The Secretary of the Queensland Friendly Societies' Association requested a ruling on the action of some of their doctors, who inserted a proviso when re-admitting returned members, that any illness resulting from war injuries would not be included in attendance. The Council supported this attitude, as the Repatriation Department has made arrangements to deal with such cases.

Lodge Rates and Minimum Wage Limit.—A sub-committee has been appointed to go into this matter and report to the Council.

Hospitals.

As in previous years, a considerable part of the Council's time has been occupied with matters pertaining to the hospitals.

After correspondence, both Cloncurry and Chillagoe Hospitals have been removed from the list, "Medical Appointments—Important Notice" in *The Medical Journal of Australia*, but Stannary Hills has been inserted, as they would not agree to the terms of the Council.

Honorary Medical Staff Appointments, Brisbane General Hospital.—Though the scheme proposed by the Branch was not accepted by the Home Secretary, the new regulations drafted by the Department proved satisfactory. In the main, they agree with the scheme submitted by the Branch last year.

Medical Officers' Relief Fund (Federal).

Up to date, the total sum received by the Branch in donations and promises amounts to about £2,220.

Australasian Medical Congress.

The Eleventh Session was held in Brisbane during August, under the Presidency of the Honourable W. F. Taylor, M.D., M.L.C. It was an unqualified success, both as regards the high standard and importance of the papers and the entertainments offered to the visiting members. The metropoli-

tan members of the Queensland Branch gave an evening garden party in the Botanic Gardens. The novelty of this function strongly appealed to the southern visitors.

General.

Alterations in Rules and By-laws.—The following alterations were moved at the general meeting of the Branch held on November 5, 1920, and subsequently approved at a special general meeting, duly convened for consideration of the subjects on November 12, 1920, and are to be placed before the Annual Meeting for confirmation.

(1) Addition to Council.—For some time it had been found that the number on the Council was inadequate. The increasing importance of the decisions of the Federal Committee of Branches made it very desirable that the Branch delegates should be kept closely in touch with the proceedings of the Council. The following amendment to the rules has been agreed to and awaits confirmation:

> That the number of members of the Council be increased to six, instead of four, to include the two Federal delegates, *ex officio*.

(2) Subscriptions.—In August the Council received a communication from the Finance Department of the British Medical Association, warning the Branch that the subscription for members outside the United Kingdom would, after January 1, 1921, be raised to £2 2s.. The reasons for this appeared in the special report on the subject in the Supplement of the *British Medical Journal* of June 5, 1920. The Council had already found that the local subscription for organization was barely sufficient to cover the increasing expenses annually, including postage, etc.. After careful consideration, therefore, they decided to recommend to the Branch the increasing of the local subscription by 9s. 6d. per member.

This was proposed at a general meeting and passed unanimously after lengthy discussion at the special meeting called for the purpose on November 12, 1920. The annual meeting will be asked to confirm the revised scale of subscriptions, which are as follow:

	£	s.	d.
Town Members (over five years' qualification)	5	5	0
Country Members (over five years' qualification)	4	15	0
Members under five years' qualification (town and country)	3	3	0

(3) Advertising.—The Branch Rules regarding professional advertising have been adversely discussed during the year. To bring them into line with the feeling of the profession, the Council appointed a sub-committee to consider them and report. In accordance with their recommendation, the following has been approved in place of the present Rules and awaits confirmation:

> No member shall be a party to the appearance of a notice of his life in the public press, or insert any advertisement beyond an announcement of change of address, or commencement or resumption of practice. Such announcement may contain only the name, address, telephone number, hours of consultation and speciality of advertiser.
>
> The whole advertisement shall be in the same type and no more spacing shall be given to it than that required for printing the same.
>
> Such advertisements shall only be inserted in the newspapers published at the place of practice and for not more than six consecutive insertions.

Minimum Scale of Fees.—In view of the frequent inquiries regarding medical fees, the Council appointed a sub-committee of three to go into the matter. The following paragraph from their report embodies their general conclusions:

> The sub-committee, having considered the question of fees and communicated with a number of medical practitioners, are of opinion that a scale of fees is desirable. Such scale would serve as a guide to Government officials and the public and to those commencing practice in Queensland. The scale should not be hard and fast—this would not be practical—but it should merely specify the minimum fees to which a doctor is entitled for his services, there being nothing to prevent him charging more if he can command it, or less where the patient is in straitened circumstances.

The scale of fees drawn up by them was, after consideration and approval by the Council, submitted to a special general meeting of the Branch on November 12, 1920, when the following resolution was passed:

> That a scale of fees is desirable.

The minimum scale was approved and will be circularized to members.

Deportation of Enemy Aliens.—The Council has to report that its continued endeavours have been at last successful and Dr. E. Hirschfeld has been deported.

Proposed Medical School.—Following on the discussion of

BRITISH MEDICAL ASSOCIATION—QUEENSLAND BRANCH.

Balance Sheet as at November 18, 1920.

Liabilities.

	£	s.	d.	£	s.	d.
Accumulation Fund—						
Balance, November 25, 1919	740	0	1			
Surplus Transferred from Revenue Account, November 18, 1920	66	6	7			
				806	6	8
Australian Medical Publishing Co., Ltd.—						
Balance Due at November 18, 1920, being Members' Payments for *The Medical Journal of Australia* not yet remitted				128	3	6
Subscriptions Paid in Advance—						
On Account of Year 1921, for Branch and Organization Funds				5	7	3
Harold Plant Memorial Fund—						
Capital	£200	0	0			
Income Accrued	18	11	6			
				218	11	6
				£1,158	8	11

Assets.

	£	s.	d.	£	s.	d.
Library	150	0	0			
Book Cases	42	0	0			
Furniture and Fittings	50	0	0			
Museum Specimens	5	0	0			
				247	0	0
Queensland Medical Land Investment Co., Ltd.—						
825 Shares paid to 10s. per share				412	10	0
Credit Balance, Bank of Queensland, Ltd., Brisbane	£76	17	5			
Credit Balance, Queensland Government Savings Bank	195	12	2			
Cash in Hand	6	16	10			
				279	6	5
British Medical Association, London—						
Refund Due				1	1	0
Harold Plant Memorial Fund—						
Commonwealth 4½% War Loan, £200	£198	0	0			
Credit Balance, Queensland Government Savings Bank	20	11	6			
				218	11	6
				£1,158	8	11

Brisbane, November 19, 1920.
(Sgd.) D. GIFFORD CROLL,
Honorary Treasurer.

Audited and found correct,
(Sgd.) ROY G. GROOM, F.C.P.A., F.I.A.Q.,
Auditor.

Dr. Falkner's paper, a sub-committee was appointed to submit a scheme for the medical curriculum of the proposed medical school. The sub-committee consisted of Drs. E. S. Jackson, A. Jefferis Turner and J. Lockhart Gibson. One meeting was held and the preliminaries discussed. No further progress has been made, owing to interruption by Congress affairs.

Representative on the Home Council.—Dr. Alexander Francis was appointed to represent the Queensland-New South Wales group and has consented to act.

Queensland Medical Land Investment Co., Ltd., Shares.—A further 300 shares in the company were purchased during the year, making a total of 825 shares held by the Branch.

Library.

The following members have kindly supplied the undermentioned journals to the Library:

Dr. A. Sutton: *Journal of the Royal Army Medical Corps.*
Dr. Eustace Russell: *The Practitioner.*
Dr. C. A. Thelander: *Annals of Surgery.*
Dr. R. Marshall Allan: *Medical Science, Abstracts and Reviews.*

The journals now subscribed to, apart from the above, are:

British Medical Journal.
The Medical Journal of Australia.
Lancet.
British Journal of Surgery.
Quarterly Journal of Medicine.
Endocrinology.
Journal of the American Medical Association.
American Journal of the Medical Sciences.
Journal of Tropical Medicine and Hygiene.
Progressive Medicine.
Edinburgh Medical Journal.
Medical Annual.

R. MARSHALL ALLAN,
Honorary Secretary.

BRITISH MEDICAL ASSOCIATION—QUEENSLAND BRANCH.

Statement of Receipts and Payments for Twelve Months Ended November 18, 1920.

Receipts.

	£ s. d.	£ s. d.
November 25, 1919—		
To Credit Balance, Bank of Queensland, Ltd., Brisbane	194 18 0	
„ Credit Balance, Queensland Government Savings Bank	127 4 7	
„ Cash in Hand	2 7 3	
		324 9 10
November 18, 1920—		
„ Subscriptions—		
British Medical Association, London	317 16 6	
The Medical Journal of Australia	300 13 6	
Queensland Branch Subscriptions	152 15 9	
Organization Fund, Queensland Branch	273 18 6	
On Account Subscriptions, 1921	5 7 3	
Rebate, British Medical Association, London	0 8 0	
		1,050 19 6
„ Dividends and Interest—		
Queensland Medical Land Investment Co., Ltd.: Dividend, 5% per annum on 525 shares	13 2 6	
Queensland Government Savings Bank: Interest	5 5 1	
		18 7 7
„ Harold Plant Memorial Fund—		
Credit Balance, Queensland Government Savings Bank, November 25, 1919	11 2 5	
Federal War Loan Interest	9 0 0	
Queensland Government Savings Bank Interest	0 9 1	
		20 11 6
		£1,414 8 5

Payments.

	£ s. d.	£ s. d.
November 18, 1920—		
By British Medical Association, London—		
Remittances on Account of Subscriptions for 1919 and 1920	330 19 0	
Active Service Members' Subscriptions Paid by Branch	12 12 0	
		343 11 0
„ Australasian Medical Publishing Co., Ltd.—		
Remittances on Account of Subscriptions to *The Medical Journal of Australia*		252 10 0
„ Queensland Medical Land Investment Co., Ltd.—		
Purchase of 300 Shares		150 0 0
„ Library Expenditure—		
Books, Journals and Bookbinding		39 3 2
„ Furniture and Fittings—		
X-Ray Plate Holder		8 1 6
„ Refund of Subscription to Member—		
British Medical Association, London	£1 1 0	
The Medical Journal of Australia	1 0 0	
Branch	1 17 6	
		3 18 6
„ Branch Expenses—		
Secretary: Salary	163 16 0	
Printing and Stationery	32 11 3	
Electric Light	12 7 11	
Bank Charges	2 9 10	
Postages and Duty Stamps and Telegrams	22 8 9	
Rent	12 0 0	
Cleaning	13 3 0	
Night Watchman	3 10 6	
Telephone	11 1 4	
Audit Fee	6 6 0	
Accountant: Preparing Taxation Information	5 5 0	
Expenses *re* Federal Committee	12 13 6	
General Expenses	19 13 3	
		317 6 4
„ Harold Plant Memorial Fund—		
Credit Balance, Queensland Government Savings Bank, Brisbane		20 11 6
„ Credit Balance, Bank of Queensland, Ltd., Brisbane	£76 17 5	
„ Credit Balance, Queensland Government Savings Bank, Brisbane	195 12 2	
„ Cash in Hand	6 16 10	
		279 6 5
		£1,414 8 5

Alterations of Rules and By-laws.

The amendments of the rules and by-laws adopted at a meeting of the Branch on November 12, 1920 (see *The Medical Journal of Australia*, December 4, 1920, page 525), were confirmed.

Election of Office-Bearers.

The following were appointed office-bearers and members of the Council:

President: Dr. A. Graham Butler, D.S.O..
Vice-Presidents: Dr. G. P. Dixon, C.B.E., Sir David Hardie, Kt..
Honorary Secretary: Dr. R. Marshall Allan, M.C..
Honorary Treasurer: Dr. D. Gifford Croll, C.B.E..
Honorary Librarian: Dr. E. S. Meyers.
Honorary Curator of Museum: Dr. J. V. Duhig.
Members of Council: Dr. J. A. Cameron, Dr. J. Espie Dods, D.S.O., Dr. J. Lockhart Gibson, Dr. A. H. Marks, C.B.E., D.S.O., Dr. J. B. McLean, D.S.O., and Dr. W. N. Robertson, C.B.E..

Presidential Address.

Sir David Hardie, the retiring President, delivered his address (see page 1).

Induction of President.

Sir David Hardie introduced Dr. Graham Butler as the new President of the Branch. He trusted that his year of office would be both a pleasurable and a profitable one.

Dr. Graham Butler, on occupying the chair, moved a vote of thanks to Sir David Hardie. He had selected a subject of great importance for his address and in it had emphasized the responsibility of the profession. The motion was seconded by Dr. Lockhart Gibson and was carried with acclamation. Sir David Hardie replied in suitable terms.

Dr. Graham Butler intimated that he would endeavour to make the meetings more interesting from a clinical point of view. He considered that the prevalent idea that the British Medical Association existed only for the advantage of the medical profession and that the interests of the public were not considered, should be strenuously combated.

Dr. D. A. Cameron suggested that the Council should endeavour to arrange clinical meetings at the various hospitals.

Dr. A. C. F. Halford referred to the annual wastage of pathological material in Brisbane. He thought the Council might provide facilities to enable members to dispose of specimens for the use of the Branch and for the future medical school.

Dr. Lilian Cooper stated that clinical meetings were held at regular intervals at the Mater Misericordiæ Hospital. In reply to a question, she stated that she did not know whether these meetings were open to the members of the Queensland Branch of the British Medical Association.

The undermentioned have been elected members of the Victorian Branch:

James Leslie Diggle, Esq., M.B., Ch.B. (Melb.), 1917, Elsternwick.
Miss Winifred Edith Kennan, M.B., B.S. (Melb.), 1920, Melbourne Hospital.

The undermentioned have been nominated for election as members of the New South Wales Branch:

Claude Blaxland Levick, Esq., M.B., Ch.M., 1920 (Univ. Sydney), Ernest Street, Hunter's Hill.
Hubert Keith Porter, Esq., M.B., Ch.M., 1920 (Univ. Sydney), Sydney Hospital.

REDUCED FEES AT PRIVATE HOSPITALS.

The Private Hospital Employers' Association recently intimated to the Council of the Victorian Branch of the British Medical Association that the proprietors of certain private hospitals were willing to reserve beds for so-called "intermediate patients." This proposal secured the approval of the Council. The Council wishes to direct the attention of members of the Victorian Branch to the following list of private hospitals at which a certain number of patients of limited means will be admitted at reduced rates:

"Allendale," Glenferrie; "Avon," Upper Hawthorn; "Corinella," Williamstown; "Egleton," Malvern; "Edlington," Auburn; "Glenhope," Brunswick Street; "Guildford," Camberwell; "Koonwarra," Armadale; "Lancewood," Kew; "Lister," St. Kilda; "Londa," Elsternwick; "Loughtane," Carlton; "Lumeah," City; "Lyneton," Kew; "Marrinook," East Melbourne; "Mount St. Evins," City; "Mt. Wise," Malvern; "Nerrina," Armadale; "Rossmore," South Yarra; "St. Aidans," St. Kilda; "St. Aidans," Moonee Ponds; "St. Andrews," Brighton; "St. Benedicts," Malvern; "St. Helens," Preston; "St. Winifred's," Hawthorn; "Somerset House," City; "Strathearn," Prince's Hill; "Tandarra," East Melbourne; "Trinafore," Moonee Ponds; "Vermador," Glenhuntly. (Incomplete.)

Country.—"Bellavia," Geelong; "Riviera," Geelong; "Cassiford House," Geelong. (Incomplete.)

We regret to announce the death on December 22, 1920, of Dr. Alfred Paul, of Hurstville, Sydney.

We have been requested by the Council of the New South Wales Branch of the British Medical Association to publish the following financial statement in connexion with the fund raised for the purpose of erecting an arch of welcome in Sydney on the occasion of the visit of His Royal Highness the Prince of Wales:

Receipts.	£	s.	d.	*Expenditure.*	£	s.	d.
Total response to Appeals	353	14	0	Mr. Sutton (contractor)	421	10	0
Donation by Architects	10	10	0	Crisp Brothers..	22	10	0
Deficiency, made up by the members of the Council	130	15	3	Wilson, Neave & Berry (architects)	44	6	0
				Postage and Exchange	6	13	3
	£494	19	3		£494	19	3

(Signed) W. H. CRAGO,
December 20, 1920. Honorary Treasurer.

Correspondence.

SPECIALISTS AND SPECIALTIES.

Sir: In reference to your note on Dr. Greenaway's admirable letter, I would ask you one question which admits of no logical answer: Why should expertness in the treatment and diagnosis of the uro-genital organs of the female be classed as a specialty and, of the apparently unimportant male, merely as an expertness?

Apparently it is the prerogative of the old to be infallible.

Yours, etc.,
W. ERNEST GRIGOR.

153 Phillip Street, Sydney,
December 17, 1920.

[We can find no guidance in any of the standard authorities on journalism for the proper procedure to be followed when a question is asked which admits of no logical reply. Pending an appointment of a member of the staff to deal with matters of metaphysics, we must ask Dr. Grigor to allow his conundrum to remain unsolved. We are indebted to him for a suggested explanation of the curious attitude adopted many years ago in the struggle between the general surgeons and the gynæcologists at public hospitals. The difference at one time was so acute that the former claimed it as their right to perform all operations on the pelvic organs through the abdominal wall and required the latter to restrict their surgical activity to vaginal operations. At about this period Dührssen developed such extraordinary skill working in the dark that the general surgeons discovered to their dismay not only that the gynæcologist was poaching on the appendical preserves, but that even the gall-bladder was not in safety. It has been suggested, although we cannot vouch for the truth of the claim, that the dentists allied themselves with the general surgeons in the endeav-

our to stem the extending activities of the gynæcologist. Today the general surgeon no longer offers objection when the gynæcologist performs an abdominal operation and we believe that the leading gynæcologists designate themselves surgeons in a limited sphere of surgery. In fine, it may be well to remind Dr. Grigor that in the leading article in our issue of November 6, 1920, it was pointed out that while the obstetrician is a specialist, "the gynæcologist has not the same grounds for distinguishing himself from other practitioners."—Ed.]

On December 21, 1920, Dr. Claude John Tozer was shot while paying a professional visit to a patient at Lindfield, Sydney. He was dead when discovered.

Medical Appointments.

Dr. Emmanuel Rosanove (B.M.A.) has been appointed Government Medical Officer at Tocumwal, New South Wales.

Approval has been given to the appointment of Dr. A. W. Holmes à Court (B.M.A.) and Dr. G. C. Willcocks, M.C., O.B.E. (B.M.A.), as Honorary Assistant Physicians at the Coast Hospital, New South Wales.

Under the provisions of *The Health Acts, 1900 to 1917*, Dr. Robert W. Telford has been appointed for a period of six months on probation a Health Officer in the Department of Public Health of Queensland.

For a period of three years, dating from January 1, 1921, Dr. W. Ernest Jones (B.M.A.) has been re-appointed Inspector-General of the Insane for the State of Victoria, under the provisions of Section 4 of the *Lunacy Act, 1915*.

During the absence of Dr. W. Ernest Jones, Dr. Robert W. Lethbridge (B.M.A.) has been appointed Deputy Inspector-General of the Insane for the State of Victoria.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxv.

(Late) German New Guinea Public Service: Medical Officer.

Government of North Borneo: Medical Officers.

Sydney Hospital: Honorary Relieving Assistant Physician.

Hospital for Sick Children, Brisbane: Resident Medical Officer.

Renwick Hospital for Infants, Sydney: Junior Resident Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
VICTORIA. (Hon Sec., Medical Society Hall, East Melbourne.)	All Institutes or Medical Dispensaries. Manchester Unity Independent Order of Oddfellows. Ancient Order of Foresters. Hibernian Australian Catholic Benefit Society. Grand United Order of Free Gardeners. Sons of Temperance. Order of St. Andrew. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

Jan. 4.—N.S.W. Branch, B.M.A., Council (Quarterly).
Jan. 11.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Jan. 12.—Northern District Med. Assoc. (N.S.W.), Narrabri (Annual).
Jan. 13.—Vic. Branch, B.M.A., Council.
Jan. 14.—S. Aust. Branch, Council.
Jan. 18.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Jan. 20.—Western Med. Assoc. (N.S.W.), Blayney.
Jan. 26.—Vic. Branch, B.M.A., Council.
Jan. 27.—S. Aust. Branch, B.M.A..
Jan. 27.—Q. Branch, B.M.A., Council.
Feb. 1.—Federal Committee of the B.M.A. in Australia.
Feb. 2.—Vic. Branch, B.M.A., Presentation of Balance Sheet, 1920.
Feb. 4.—Q. Branch, B.M.A..
Feb. 8.—N.S.W. Branch, B.M.A., Ethics Committee.
Feb. 10.—Vic. Branch, B.M.A., Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney. (Telephone: B. 4635.)